

## C. Center for Substance Abuse Prevention

### Overview

	<b>1999 <u>Actual</u></b>	<b>2000 Pre-rescission <u>Appropriation</u></b>	<b>2000 Final <u>Appropriation</u></b>	<b>2001 <u>Estimate</u></b>	<b>Increase or <u>Decrease</u></b>
<b>BA . . . . .</b>	<b>\$479,800,000</b>	<b>\$467,305,000</b>	<b>\$466,824,000</b>	<b>\$468,429,000</b>	<b>+\$1,605,000</b>

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As the primary federal agency responsible for substance abuse prevention, CSAP's goal is to reduce substance abuse across this nation. CSAP's unique niche is serving as the bridge from research to practice though: 1) *Knowledge Development* or field-testing evidence-based approaches to see if they remain effective with diverse populations and implemented under real world conditions, and 2) *Knowledge Application* or developing user-friendly and culturally-appropriate dissemination materials, technical assistance and training programs to increase the capacity of States and communities to adopt these effective prevention programs. CSAP's *High Risk Youth* program dedicates knowledge development resources to field testing research-based programs among specific populations of youth who are at increased risk of substance abuse. Through partnership efforts with other Federal agencies, States, and communities, the *Targeted Capacity Expansion (TCE)* program addresses emerging needs for drug abuse prevention, and improves the accessibility and quality of prevention services. The 20 percent prevention component of the Substance Abuse Block Grant is the primary source of state prevention program support.

Substance abuse is a serious public health problem costing taxpayers \$246 billion or about \$1,000 per person annually. If you add tobacco, the cost rises to \$428 billion. Substance abuse is related to many health problems (e.g., violence and aggression, teenage pregnancies, fetal alcohol and drug syndrome, car crashes, HIV/AIDS, accidental injuries, depression, and suicide). The most cost-effective way to reduce these high personal and economic losses is by preventing them.

Substance abuse prevention is a key component of a comprehensive health strategy. Once a person is a drug abuser, significant damage has already occurred which could have been avoided by providing science-based positive youth development, family strengthening and community mobilization programs. The U.S. Census Bureau projects a 21% increase in the number of youth aged 12-20 or 6.5 million more young people over the next 15 years. Early childhood and adolescence is the most vulnerable age for alcohol and drug initiation and abuse. Hence, investment in primary prevention remains a federal priority. If we do not have an immediate 50% reduction in the initiation rate of alcohol and drug use and the rate of initiation remains the same, the demand for treatment will increase by 57% in the next 15 years. Reducing the initiation rate is essential in any comprehensive effort to close the treatment gap.

Drug abuse in youth is still at unacceptably high levels. Adolescent drug use rose from 5.3 percent

monthly use at its lowest point in 1992 to a high of 11.4 percent in 1997. The SAMHSA Household Survey suggests a leveling off or a decrease in 1998 and the Monitoring the Future Study released in December 1999 suggests this downward trend is continuing (MTF shows a 2 year decline among 8<sup>th</sup> graders). While this is good news it does not mean that we can relax our focus on prevention. We must continue to strive toward the National Drug Control Strategy goal to reduce initiation rates by 2007.

As recently as five years ago, only a very few effective prevention strategies had been identified. Since that time, new prevention strategies have been identified as being effective in preventing, reducing, or delaying the onset of substance abuse. Effective prevention programs include behavioral parent training, family and children's skills training, mentoring and tutoring, school climate change, after school programs, policy changes, community coalitions, and others. They work not only to reduce tobacco, alcohol and drug abuse in youth, but also to improve developmental outcomes and mental health.

We have also learned some prevention approaches do not work. Drug education alone does not work without behavior changes promoted through social and life skills training programs. Behavioral parent training, family skills training, family therapy, and in-home family support programs are highly effective. A recent meta-analysis commissioned by CSAP found that family strengthening programs were 9 times more powerful in reducing the risks for drug abuse than the most powerful school-based programs.

CSAP efforts are critical to the dissemination of effective prevention programs developed by SAMHSA and NIH research grants. Through rigorous evaluation of CSAP programs and collaboration with NIH, we have identified a number of effective prevention programs. CSAP has conducted the cross-site field-trials to see if they still work with diverse populations and reduced experimental control; and CSAP and other federal and state agencies have disseminated these effective prevention programs. We have included a number of effective CSAP prevention programs within a National Registry of Effective Prevention Programs. The 25 State Incentive Grant (SIG) states must use 85 percent of their grant funds to expand the use of evidence-based prevention programs in communities. Further, all grantees in the Community-Initiated and Family Strengthening grant programs must identify, culturally-adapt, implement and evaluate only evidence-based prevention programs.

The value of CSAP's program agenda is supported by the following points:

- **CSAP's Prevention Programs Reduce Substance Abuse.** All of CSAP's cross-site studies have produced positive results and valuable lessons learned. The *Community Partnership Grant Program* implemented in 251 communities reduced the rates of alcohol and drug use in both adolescent and adult males. This year we found through cross-site analyses of 49 grants that overall our *High Risk Youth Program grants* were effective in reducing substance use in adolescent boys (see following accomplishment description). More work is required to identify and disseminate gender-relevant prevention approaches. Those for girls need to be more family-focused rather than the social and recreational skills training approaches found effective for boys. Hence, we are now seeing progress and must continue field-testing and disseminating evidence-based approaches through CSAP's Knowledge

Development (KD) cross-site community studies and CSAP's Knowledge Application (KA) systems.

- **CSAP's Prevention Programs Also Reduce Aggression, Violence, Depression, Suicide, and School Failure.** The High Risk Youth program has shown that precursors of drug use can be prevented. CSAP has proven solutions that need to be disseminated to reduce school and community violence. Every cross-site prevention study that CSAP has completed has demonstrated positive reductions in the precursors of drug use--youth aggression, violence, and mental health problems. CSAP's *High Risk Youth*, *Community Partnership* and *Developmental Predictor Variable* cross-site evaluations all demonstrate that CSAP-funded substance abuse prevention strategies are also effective in reducing conduct disorders and aggression, depression, school failure, and family conflict while improving school bonding, cooperation, and academic performance.
- **CSAP's Programs Identify and Promote Effective Prevention Practices.** CSAP systematically reviews and evaluates community-based substance abuse prevention programs. We have identified seven exemplary prevention programs from our High Risk Youth grant portfolio as well as other NIH and state prevention programs. These evidence-based programs are being disseminated widely in Here's Proof Prevention Works kit through the National Clearinghouse for Alcohol and Drug Information (NCADI), through six regional training centers (CAPTs), and partnerships with national organizations like the National Association of Elementary School Principals, Boys and Girls Clubs and the National Civic Alliance of national service clubs such as the Lions, Rotary, Elks, 100 Black Men, and faith communities.
- **CSAP Programs Improve the Quality of Prevention Services.** By the end of FY 2000, CSAP SIG program will have funded half of all the States for \$2 to 3 million dollars each with a mandate to use 85% of grant funds for implementing science-based programs. CSAP's six regional Centers for the Application of Prevention Technologies (CAPTs) work with communities to provide technical assistance and training in selecting and implementing the best prevention programs to meet their local needs. CSAP provides leadership from the six regional CAPTs to the ONDCP/Department of Justice's Drug Free Communities grantees through training in identifying and implementing best prevention practices. Improving the quality of prevention services offered throughout the Nation will improve prevention service effectiveness and outcomes and reduce substance abuse.
- **CSAP Programs Improve the Availability of Prevention Services.** The State Incentive Grant (SIG) program requires states to mobilize all state and community stakeholders to develop a comprehensive state plan, to coordinate and leverage many different prevention funding streams, and to implement and evaluate evidence-based prevention approaches that are coordinated and match local needs assessments. This SIG grant program has reduced services duplication and resulted in more cost-effective and cost-efficient allocation of prevention resources. The outcome is greater availability of quality programs reaching a greater number of

individuals in need of these services.

- **CSAP Programs Build Stronger Federal/State/Local Partnerships.** CSAP is taking the lead in promoting partnerships among public and private agencies to build a more effective National Prevention System. CSAP partners with other Federal agencies to support: 1) *States* in gaining maximum benefit from their prevention expenditures, including the 20% prevention set aside within the Substance Abuse Prevention and Treatment Block Grant; and 2) *local communities* in accessing and applying science-based practices. A National Substance Abuse Prevention Framework was created last March by the 500 delegates attending CSAP's National Prevention Congress. It includes the two major prevention goals from the White House National Drug Control Strategy and 30 new prevention objectives based on what additional knowledge is needed to reduce drug use in this country. This framework is being used by states and CSAP to develop their own coordinated strategic plans. Communities are registering on a dedicated web site their activities under each of the 30 objectives to create a national action plan for prevention and annual report card on accomplishments. A process for voluntary reporting on CSAP's Core Outcome Measures and Minimum Data Set process measures is also being developed.
- **CSAP Programs Support National Demand Reduction Goals.** CSAP programmatic efforts are directly in support of the President's National Drug Control Strategy (NDCS). Predominantly addressing the NDCS Goal 1, *Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco*, CSAP efforts focus on impact targets relating to reducing the prevalence of past month use of illegal drugs and alcohol among youth by 20 percent by 2002 and by 50 percent by 2007 and to increasing the average age for first time drug use by 12 months by 2002 and by 36 months by 2007. CSAP programs also contribute to NDCS Goal 3, Objective 2, which is to *promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes: drug testing, education, prevention, and intervention*.

## **FY 2001 Agenda**

The FY 2001 budget reflects CSAP's commitment in moving the substance abuse prevention field forward in the 21<sup>st</sup> century. The Center's program portfolio continues to build on the strengths of current and past cross-site KDA evaluations to identify effective practices while our TCE programs promote implementation of these best practices and address critical prevention capacity needs of States and communities. Within the budget request, CSAP will continue all ongoing KDA efforts, and add several new projects to our standing Community Initiated Intervention and Strengthening Families grants programs.

In the area of Knowledge Application, CSAP will continue the National Clearinghouse on Alcohol and Drug Information and public education efforts. CSAP will also begin efforts to develop a Prevention Decision Support System (PDSS) to disseminate evidence-based prevention intervention programs on the internet. CSAP's National Center for the Advancement of Prevention (NCAP) will continue its

identification of model programs through the National Registry of Effective Prevention Programs, and will disseminate effective programs through its 40-plus State of the Science Papers and Annual Review of the Status of Substance Abuse Prevention.

Within its Targeted Capacity program, CSAP will support approximately 14-16 new State Incentive Grants increasing the total of states receiving SIG awards to approximately 39-41 states. SAMHSA is proposing to modify the program to allow for matching funds from the States and to vary the size of the grant award according to State need. Because of significantly increased demand for services, we will also need to expand the six regional CAPTs that provide training and technical assistance in selecting and implementing best practices to the Drug Free Communities program, SIG States, and others.

## **KDA PROGRAM ACCOMPLISHMENT**

### **Program Initiative: High Risk Youth Program**

The High Risk Youth Cross-Site Evaluation analyzed the high risk youth portfolio including Female Adolescent Grants, High Risk Youth Demonstration grants and Replication grants to determine their broad-based effectiveness in preventing, delaying the onset or reducing substance abuse.

**Goal 1:** Assess the effectiveness of intervention strategies in decreasing the risk factors and increasing the protective factors related to substance abuse.

#### **Findings:**

- Analyses demonstrated clearly that overall protective factors decrease sharply and risk factors for substance abuse increase dramatically between the ages of 11 and 16.
- Structural equation models were developed using baseline data to delineate paths to substance abuse. The first and most potent is through the family; not only is family context related directly to reported levels of substance abuse, but it also contributes to peer factors related to substance use.
- A second path related to substance abuse includes a number of personal characteristics related to self-control, school efficacy and values. The third path includes contextual factors—school environment, community environment and neighborhood risk.

**Goal 2:** Assess the impact of CSAP funded programs in preventing or reducing substance abuse and related problem behaviors.

#### **Findings:**

- Preliminary results show clearly that relative to controls/comparisons, CSAP program intervention demonstrated statistically significant decreases in substance use in older youth.
- The younger cohort demonstrated little change due to the low basal rate.

#### **Application:**

- Data from the High Risk Youth Cross-Site baseline demonstrate the profound increase of risk to youth for substance use as a function of age; identify the nature of risk/protective factors; and provide clear suggestions concerning important aspects of effective prevention programs.
- This important work provides additional guidance regarding both the timing and content of effective prevention interventions.
- Additional analyses will be targeted to determine thresholds for effectiveness as well as

differential effectiveness of similar interventions across different identifiable subgroups.

- Results from these analyses will provide crucial guidance to the field not only about the essential ingredients for effective interventions but also how these ingredients should be structured and phased for maximal effect with different populations.

## **KDA PROGRAM ACCOMPLISHMENT**

### **Program/Initiatives: Predictor Variables Program**

#### **Goal:**

The Predictor Variables Program study focused on four variables: social competence, self-regulation and control, school bonding and cognitive development, and parental involvement. The purpose of this study is to determine which interventions in these areas at which development stage work effectively in parenting and redirecting negative behaviors that are predictive of substance abuse. The ultimate aim is to promote emotional well-being in children at risk and to enhance their social and emotional development.

#### **Findings:**

- Preliminary finding show significant improvement in the intervention group relative to the control group in: improved parenting practices, increased family cohesion, increased family organization and decreased family conflict. Additionally, children in the intervention group showed significant reductions compared to the controls in aggressive disruptive behaviors and concentration problems.
- Interim results also reveal the rates of chewing tobacco were reduced from 2.6% to 0.5% in the intervention group, while the comparison group rates doubled from 1.1% to 2.3%.
- The use of alcohol was 4% lower in the intervention group compared to the control group.
- The rates of overall use of one or more drugs in the control group almost doubled from 6.8% to 12.4%, while this increase is less than half of a percentage point (0.4.%) in the intervention group.

#### **Application:**

- These data provide CSAP, States and local communities guidance to maximize the effectiveness of prevention interventions.
- Disseminating study findings is a key component of to facilitate the use of effective interventions.

**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION**  
**Center for Substance Abuse Prevention**  
**Mechanism Table**  
*(Dollars in thousands)*

	FY 1999 Actual		FY 2000 Pre-rescission Appropriation		FY 2000 Final Appropriation		FY 2001 Estimate	
<b>Knowledge Development and Application:</b>	<b>No.</b>	<b>Amt.</b>	<b>No.</b>	<b>Amt.</b>	<b>No.</b>	<b>Amt.</b>	<b>No.</b>	<b>Amt.</b>
Grants/Cooperative Agreements:								
Continuations.....	70	\$31,305	166	\$40,108	166	\$39,785	30	\$18,954
Competing:								
New.....	117	15,896	---	---	---	---	11	4,292
Renewal.....	---	---	---	---	---	---	---	---
Supplements:								
Administrative.....	---	1,500	---	---	---	---	---	---
Total, Grants/Cooperative Agree.....	187	48,701	166	40,108	166	39,785	41	23,246
Contracts.....	16	27,512	15	18,319	15	18,172	15	25,270
Technical Assistance.....	---	1,080	---	1,271	---	1,260	---	1,118
Review Costs.....	---	298	---	324	---	324	---	388
<b>Total, Knowledge Development &amp; Appl.....</b>	<b>203</b>	<b>77,591</b>	<b>181</b>	<b>60,022</b>	<b>181</b>	<b>59,541</b>	<b>56</b>	<b>50,022</b>
<b>Targeted Capacity Expansion:</b>								
Grants/Cooperative Agreements:								
Continuations.....	25	63,101	70	63,141	70	63,141	60	39,201
Competing:								
New.....	50	11,065	5	14,090	5	14,090	19	42,176
Subtotal, Grants.....	75	74,166	75	77,231	75	77,231	79	81,377
Contracts.....	2	2,682	2	1,682	2	1,682	2	1,682
Technical Assistance.....	---	1,074	---	1,074	---	1,074	---	1,760
Review Costs.....	---	296	---	296	---	296	---	388
<b>Total, TCE.....</b>	<b>77</b>	<b>78,218</b>	<b>77</b>	<b>80,283</b>	<b>77</b>	<b>80,283</b>	<b>81</b>	<b>85,207</b>
<b>High Risk Youth:</b>								
Cooperative Agreements:								
Continuations.....	13	6,159	16	6,900	16	6,900	3	2,000
Competing:								
New.....	3	707	---	---	---	---	13	4,740
Subtotal, Cooperative Agreements.....	16	6,866	16	6,900	16	6,900	16	6,740
Contracts.....	---	100	---	100	---	100	---	200
Technical Assistance.....	---	25	---	---	---	---	---	60
Review Costs.....	---	---	---	---	---	---	---	---
<b>Total, High Risk Youth.....</b>	<b>16</b>	<b>6,991</b>	<b>16</b>	<b>7,000</b>	<b>16</b>	<b>7,000</b>	<b>16</b>	<b>7,000</b>

**C. Center for Substance Abuse Prevention**  
**1. Knowledge Development and Application**

	<b><u>1999 Actual</u></b>	<b><u>2000 Pre-rescission Appropriation</u></b>	<b><u>2000 Final Appropriation</u></b>	<b><u>2001 Estimate</u></b>	<b><u>Increase or Decrease</u></b>
<b>BA .....</b>	<b>\$77,591,000</b>	<b>\$60,022,000</b>	<b>\$59,541,000</b>	<b>\$50,022,000</b>	<b>-\$9,519,000</b>

**2001 Authorization**

**PHSA Section 501.....Indefinite**

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***Purpose and Method of Operation***

The two-fold goal of KDA efforts is to assure individuals have the information needed to understand the nature and consequences of substance abuse and State and community prevention practitioners have the knowledge, skills, tools, and assistance needed to implement science-based interventions proven effective in preventing, reducing, or delaying substance abuse and its associated problems.

CSAP's Knowledge Development (KD) programs identify, implement, and field-test through cross-site evaluation, prevention programs to determine their effectiveness with diverse populations in real-life environments. These KD grantees also create new curriculum packages providing practical, cost-effective materials useful with different cultural populations. These cross-site studies are using coordinated core measures and methods allowing the data to be pooled and analyzed across many different sites, thus increasing our knowledge of what works, for whom, and under what circumstances.

CSAP's Knowledge Application (KA) programs disseminate and foster implementation of best practices by States and community-based providers through the National Center for the Advancement of Prevention (NCAP), the Centers for the Application of Prevention Technology (CAPTs), the National Clearinghouse for Alcohol and Drug Abuse Information (NCADI), and the new Prevention Science Decision Support System (PDSS). The PDSS is a web-based expert system to provide immediate answers to prevention providers' questions along with downloadable prevention documents and materials. This web-based dissemination system is designed to be a more cost-effective method of meeting the increased number of requests at our clearinghouse, due in part to the White House's ONDCP media campaign.

Funding for the Knowledge Development and Application program during the last five years has been as follows:

	<u>Funding</u>	<u>FTE</u>
1996	\$91,999,000	---
1997	\$155,869,000	—
1998	\$84,321,000	—
1999	\$77,561,000	—
2000	\$59,541,000	—

### ***Rationale for the Budget Request***

The FY 2001 budget request includes a total of \$50,022,000 for CSAP's KDA portfolio. This is approximately \$10 million below the FY 2000 appropriation. The requested level is sufficient to support all ongoing program efforts. Within the funds available, CSAP proposes to expand Community Initiated Interventions program (\$2 million), Parenting and Family Strengthening (\$2 million), and begin developing Prevention Decision Support System (\$.4 million).

#### **A. Knowledge Development**

Identifying, testing, and evaluating prevention practices is the primary responsibility of CSAP's knowledge development program. CSAP's grantee programs are rigorously evaluated to determine effectiveness of researched-based prevention programs when implemented by community providers in real world settings with diverse populations. Cross-site and other evaluation findings identify best prevention practices to disseminate to the field; help to improve service delivery, and identify gaps in knowledge to be incorporated into CSAP's prevention programming. For example, a significant finding from CSAP's cross-site evaluation of the Community Partnership program and the High Risk Youth grant program showed unexpected gender differences in the results, namely, the reductions in drug use were stronger for males than for females. This clearly highlighted the need for gender-specific interventions which were then included within CSAP's Community Initiated Intervention program.

Since its creation by Congress in FY 1996, CSAP has conducted seven KD cross-site grant programs. The first cohort of KD grants included ten 4-year grants awarded under the Developmental Predictor Variable grant program. The purpose of these grants was to discover the most effective prevention programs for different age groups of youth in urban or rural settings. Hence, grants were awarded to a matrix of urban and rural programs across four developmental periods. Each had to test comprehensive approaches to prevention including school, community and family-focused approaches. The evaluators in this cross-site represent some of the best prevention researchers and the findings will be unprecedented in the prevention field. Through collaboration on outcome measures and data collection and analysis strategies, SAMHSA programs are advancing the prevention field among coordinated partnerships.

Several other KD efforts such as the Children of Substance Abusing Parents (COSAPs) grant program; the Pregnant and Parenting Adolescents grant program; the early childhood Starting Early Starting Smart grant

program, which is a collaborative with the Casey Family Program, will be completed by the end of FY 2000. Two programs, Community-Initiated program grants and the Family Strengthening grants, continue into FY 2001.

Initiated in FY 1999, the Community Initiated Interventions (CII) Grant Program responds to widely expressed need and support from the substance abuse prevention field. Establishment of this program was consistent with Congressional expectations that KDA results are relevant to local needs and current practice, readily integrated into prevention practice nationwide, and disseminated and adopted on the widest possible scale.

The CII program encourages each community applicant to determine the topic of study according to its needs and then test, adapt, refine and/or replicate proven research findings among different populations and in disparate community settings. As such, the CII program assures effective prevention strategies are relevant and appropriate to communities, by adapting, disseminating and applying programs meeting its unique needs. CSAP supports each community effort by providing expertise from field-tested prevention models identified in its High Risk Youth, Predictor Variable, and other knowledge development programs. Although CII projects are too new to yield preliminary results, the distribution of the topic areas funded clearly indicates the diverse needs identified by the communities and the breadth of proven prevention interventions that need to be further refined to suit local problems and populations. The FY 2001 request includes \$2.0 million for new grants in this area.

The Parenting and Family Strengthening Intervention Program is also continued in FY 2001, with \$2.0 million to be awarded in new grants. CSAP's Prevention Enhancement Protocol System has completed a review of the family-focused research literature and determined that only four approaches meet the highest level of evidence for effectiveness: 1) behavioral parent training, 2) family skills training, 3) family therapy, and 4) in-home family support. A meta-analysis of all family programs with results concluded that these family-based prevention programs are 9 times more powerful in making positive changes in youth helpful in reducing later drug use than are school-based programs. Hence, field-testing and helping communities to select the very best family strengthening program must be an essential part of any comprehensive prevention program. Ninety-five community agencies received funding in September, 1999. Through a carefully designed naturalistic study, these 95 communities are being supported to use one of 28 of the best parenting and family programs addressing local needs. These 28 programs represent the best of over 70 parenting and family programs reviewed by a panel of experts.

Grantees are being trained, during the spring of 2000, in community and organizational readiness to determine the best parenting programs to implement and how to implement these programs with integrity.

This program will increase local community capacity to deliver best practices in effective parenting and family programs while documenting the decision-making processes for selecting and testing effective interventions impacting target families.

Like the Community Initiated Interventions, Family Strengthening programs target local community needs and will be integrated into prevention practice and disseminated on the widest possible scale.

## **B. Knowledge Application**

Disseminating and promoting best prevention practices learned through CSAP's knowledge development programs is the responsibility of CSAP's Knowledge Application (KA) programs. As such, CSAP's KA programs further develop and disseminate the information, materials, and tools needed by the public and prevention practitioners to expand the use of cutting edge information and best practice models in the Nation's communities. CSAP program findings are synthesized by CSAP's National Center for the Advancement of Prevention (NCAP) and disseminated to the field through a variety of application mechanisms including the National Registry of Effective Prevention Programs (NREPP) and the Prevention Decision Support System (PDSS). CSAP's application programs work in tandem with CSAP's SIG and CAPT programs to help build prevention capacity at the State and local levels. Program-generated information and materials are also widely disseminated by the National Clearinghouse for Alcohol and Drug Information (NCADI) and used as the basis for nation-wide prevention education campaigns such as *Girl Power!* In 2001, CSAP will continue all major knowledge application programs including:

The ***National Center for the Advancement of Prevention (NCAP)*** synthesizes prevention research and evaluation findings; develops new prevention knowledge and tools; examines trends and patterns of substance use and precursors of use; translates scientific and practice-based knowledge into practical and timely prevention products for States and the field; and fosters the adoption and application of science-based prevention practices. Among NCAP products are Technical Reports on such topics as *Alternative Activities and Alternatives Programs in Youth-Oriented Prevention* and *Strategies for Reducing Sales of Tobacco Products to Minors*; Implementation Guides on *Effective Community Mobilization* and *Tobacco Outlet Inspections*; and Resource Papers such as the *AESOP Overview of the Science and Models of Prevention*. Products have been used to bolster CSAP training and technical assistance activities, to improve CAPT efforts and to change/improve program strategies and effectiveness in the field.

The ***National Clearinghouse for Alcohol and Drug Information (NCADI)*** is the largest information clearinghouse in the country for alcohol and drug information. It responds to about 200,000 information requests annually and distributes over one million free or at-cost Federal publications, audiotapes, and videotapes per month. The current level of demand (as of October 1999) for NCADI services during a typical month is reflected in the following profile: 33,316 requests/month; 59 percent of inquiries are made by phone; 3 percent by mail; 30 percent by e-mail; and 2 percent by fax/in-person. NCADI has been the national resource for consumer materials for ONDCP's National Youth Anti-Drug Media Campaign that was launched in mid 1998. Infrastructure support includes a toll-free number, extended hour phone coverage, and provision of bulk quantities of materials (1,050 tons in 1998) to respond to campaign-generated requests. After the first two weeks of the campaign, the NCADI contract experienced a 121 percent increase in caller volume as a result of the media advertising in 75 media markets. Hits to the NCADI website, Prevline, now exceed 4 million per month; hits increased from 13.3 million in 1997 to 34.5 million in 1998. During one day NCADI answered 4200 telephone calls stimulated by a Sunday *Parade Magazine* article. Historical records indicate that caller volume increases steadily each year regardless of broad-based media efforts.

The ***Prevention Decision Support System (PDSS)*** is an emerging CSAP program designed to meet the needs of the practitioner, or "end-user" by increasing electronic access to best practices. Computer software will integrate and provide prevention practitioners with immediate access to local needs assessment

data, logic models, and an expert system to help select the best practices to meet local needs. The PDSS will be equipped to provide on-line, real-time information, training and technical assistance to its customers relative to needs assessments, logic models, program selection and implementation, community resources, resource development, and report writing. It will also include a complete Management Information System, outcome measures and data analysis package. The system will be compatible with personal computers and will be distributed on CD-ROMs. CSAP began preliminary work on the PDSS during FY 1999; a prototype should be completed by mid-2000. In FY 2001, CSAP's will focus on fully developing the modules that comprise the core of PDSS services.

The ***National Registry for Effective Prevention Programs (NREPP)***. CSAP's NREPP is an ongoing repository of guidance to the substance abuse prevention field. The NREPP contains implementation and outcome information on substance abuse prevention intervention projects sponsored by all Federal agencies, State governments, foundations, and corporations. Publicly available on the world wide web at <http://www.preventionregistry.org/trial.htm>, NREPP provides opportunities for field nominations of standardized programs. These programs must show evidence of reducing risk factors or increasing protective factors pertaining to substance abuse to be considered in the registry. Nominations may be made for new, innovative programs as well as for adaptations or replications of established or science-based prevention models. Teams of trained evaluators review programs based on 15 criteria including: theory, fidelity of interventions, process evaluation quality, sampling strategy and implementation, attrition, outcomes measures, missing data, outcome data collection, analysis, other plausible threats to validity, integrity, utility, replications, dissemination capability, cultural- and age- appropriateness. This review process serves to identify a subset of "model" prevention efforts and rates their evidence using a five star system.

CSAP promotes selected models from the NREPP in three ways: 1) by supporting the development of program materials for dissemination, 2) by connecting program developers with organizations able to help in the dissemination efforts, and 3) by promoting model programs nationally through CSAP's State Incentive Grant recipients and regional Centers for the Application of Prevention Technologies.

**C. Center for Substance Abuse Prevention**  
**2. Targeted Capacity Expansion**

	<b>1999 <u>Actual</u></b>	<b>2000 Pre-rescission <u>Appropriation</u></b>	<b>2000 Final <u>Appropriation</u></b>	<b>2001 <u>Estimate</u></b>	<b>Increase or <u>Decrease</u></b>
<b>BA .....</b>	<b>\$78,218,000</b>	<b>\$80,283,000</b>	<b>\$80,283,000</b>	<b>\$85,207,000</b>	<b>+\$4,924,000</b>

**2001 Authorization**

**PHSA Section 501.....Indefinite**

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***Purpose and Method of Operation***

CSAP's Targeted Capacity Expansion (TCE) programs help States and communities address current and specific gaps in availability of substance abuse prevention services and improve the quality of prevention services provided. The TCE programs are the major efforts CSAP uses to promote science-based "best practices" in State and community prevention service systems. These programs address CSAP's GPRA Goal 3: Assure services availability/meet targeted needs; and GPRA Goal 2: Promote the adoption of best practices. TCE programs also support National Drug Control Strategy Goals 1 and 3.

CSAP's Targeted Capacity program is comprised of three major efforts:

**1. State Incentive Grants**

Data from the 1995 National Household Survey on Drug Abuse showed disturbing increases in drug use among youth, particularly in marijuana use, which prompted a DHHS review of substance abuse prevention services nationwide. The review found an inefficient system characterized, at the State level, by: 1) uncoordinated and fragmented use of resources, knowledge, and information relating to what works in prevention; 2) lack of a systematic evaluation of programs and practices to identify effective, scientifically derived approaches; and 3) lack of a systematic approach for disseminating these research findings to improve prevention services.

The State Incentive Grant program was established to respond to these findings. The program's two key goals were to: effect changes at the State level by ensuring that States better coordinate the allocation of disparate substance abuse prevention funding streams; and to effect changes in the availability and quality of State prevention services by funding critical, unmet prevention needs and ensuring new programs use state-of-the-art prevention practices. Under the SIG program, States award 85% of the funds to subrecipient communities to implement new or expanded prevention programs that employ best prevention practices.

The SIG Program design married the results of CSAP's High Risk Youth (HRY), Community Partnership and Community Coalitions Demonstration Grants. It helps States and communities to implement the best

practices identified to date by the HRY and other CSAP demonstrations programs while using the Community Partnership model as the delivery mechanism. It is important to note that at least three of the highly effective prevention models identified by CSAP's High Risk Youth programs are identified as among the top 10 most implemented programs by SIG subrecipients.

By the end of FY 2000, a total of 25 SIGs awards will have been made to States and the District of Columbia. States are funding between 20 and 30 subrecipient communities each. Depending on the State's prevention plan, these community subrecipients can be counties, cities and/or towns, community coalitions or partnerships, Indian Reservations, Community-School Districts and other jurisdictional arrangements appropriate to the particular State. Each of these subrecipient communities in turn support two or more science based prevention programs in their community. In the State of Washington, for example, each community subrecipient supports up to 4 targeted prevention programs at the local level. In another case, Colorado has used existing infrastructure -- Community School Districts -- as the jurisdictional entity to receive its SIG funds. As a result, each of the Colorado School Districts then funds 2 to 4 individual schools, or clusters of schools to implement prevention programs. By using existing infrastructure, States have been able to put into place a larger number of science-based prevention programs.

It is estimated that approximately 49 percent of the subrecipients are community-based organizations; 23 percent are coalitions and partnerships, 22 percent are local governments, and 6 percent are schools and school districts. These organizations are using SIG dollars to increase services capacity by more than 2,500 science-based prevention programs estimated to reach over 1 million participants by FY 2001.

**Estimated Number of Subrecipients, Prevention Programs, and Individuals Served through  
SIG Funding FY 1997 - 2001**

	<u><b>1997</b></u>	<u><b>1998</b></u>	<u><b>1999</b></u>	<u><b>2000</b></u>	<u><b>2001</b></u>
Number of States/Year	5	14	2	4	14-16
Number of States (Cumulative totals)	5	19	21	25	39-41
Subrecipient Organizations (Cumulative totals)	125	475	525	625	1,025
Prevention Programs Supported (Cumulative totals)	312	1,187	1,312	1,562	2,562
Number of Participants* (Cumulative totals)	138,437	525,841	581,216	691,966	1,134,966

\*based on estimated 443 participants per program

The State Incentive Grants are impacting substance abuse prevention in the States at three levels: the State level, the community level, and the project level where prevention services are delivered. Major outcomes to date include:

- Promoting use of best practices by increased science-based programs in communities. Over 60 percent of all current SIG-funded community programs are reported or documented as science-based. For example, in Illinois, as a result of SIG changes their SAPT Block Grant recipients (over 100) must incorporate evidence-based prevention in their programming.
- Expanding prevention services capacity at the community level. More than 1300 new and/or expanded prevention programs will have been put into place by the 21 SIGS awarded through the end of FY 1999. More than 500,000 individuals will have improved access to quality prevention programs.
- Reducing risk and drug use. Program level data available to date show that SIG funded programs have been effective in reducing substance abuse in the communities where implemented. For example, Kansas reduced drug-related violence as a result of a SIG-sponsored community coalition.
- Leveraging of SIG funds to increase State service capacity in prevention. Through the involvement of State Governors, SIG States have successfully leveraged other prevention funds from public/private sector sources through matching funds-in some cases, up to 10 times the grant amount. Governors have conducted Statewide inventories of prevention resources; identified and leveraged local matching funds; and merged resources from United Way, Safe and Drug Free Schools, State and local agency grants, and private entities. Moreover, they have integrated the 20 percent SAPT Block Grant set-aside funds into their SIG prevention plans. Kentucky, for example, has added approximately \$1.5 million in state funds for infrastructure supporting science-based prevention programs and Kentucky communities have leveraged \$1.2 million each year to match the \$2.5 million in SIG funds.
- Increasing State level coordination and collaboration. Governors have effectively coordinated their prevention resources to create a more comprehensive, multi-agency system of prevention service delivery. They have increased state-wide collaborative approaches for responding to the specific problems of youth drug use and created Governor's Councils on Substance Abuse Prevention to guide youth-focused prevention strategies. Illinois, North Carolina and Massachusetts have used the SIG opportunity as a vehicle for State agencies to build and strengthen new collaborations in prevention programming. Data from 11 SIG states indicate the average amount of funds coordinated due to SIG efforts approximates \$28.2 million.
- Optimizing use of State and Federal prevention dollars for youth services. The SIG program has heightened State awareness and response to the role prevention plays in reducing the demand for drugs among youth. In Oregon, as a direct result of the SIG, the State now includes a separate line item for substance abuse prevention, giving drug prevention a higher priority status. SIG States are taking full advantage of the SIG program, and nearly all have committed to integrating their Block Grant monies into their strategic plans as a result of SIG. In Vermont, SIG funding has prompted changes in the way SAPT block grant funds have been allocated, especially to support science-based prevention

programs.

## **2. Centers for the Application of Prevention Technologies**

The National Centers for the Application of Prevention Technologies (CAPTs) were established in FY 1998 as essential partners to the State Incentive Grant Program (SIG), intended to provide the necessary training and technical assistance to SIGs and their subrecipient grantees. The centers increase the recipients' knowledge about effective prevention strategies, principles and programs and identify and implement the best practices for local real-life settings. This is extremely important to assure the best outcomes for the people receiving prevention services.

The CAPTs, located in six regional sites, comprise a major national resource supporting the widespread use of scientifically sound and effective substance abuse prevention interventions. Demand for CAPT targeted capacity building services has been significantly increased. In FY 1998, the CAPTs served 19 SIGs. By FY 1999 they served 21 SIGs, 525 SIG sub-grantees, 224 Drug Free Community grantees funded by ONDCP and OJJDP, trained many Safe and Drug Free School grantees funded by the Department of Education, and participated in the U.S.-Mexico Border Initiative. The rate of requested technical assistance and its successful delivery by the CAPTs in the SIG States had increased 400% by the close of FY 1999. Similarly, there was an increase in excess of 200% in training of science-based prevention to the SIG States and their sub-recipients. In FY 2000, the CAPTs are projected to serve: 25 SIGs, 625 SIG sub-grantees, all 25 non-SIG State programs, 300 ONDCP Drug Free Community grantees, 95 Family Strengthening grantees, 40 Substance Abuse/HIV Prevention grantees, and many Tribes and U.S. Territories/Jurisdictions in the Pacific and Caribbean.

The success of the CAPTs has increased the interest in and use of science-based prevention in States and communities. Participants in the first National Prevention Congress, convened by CSAP in March 1999, confirmed this interest by recommending enhancement of the nation's technical assistance and training capacity to support science-based prevention program implementation and strategic planning as a cross-cutting theme critical to the success of the National Prevention System. The CAPTs meet this need; no other entity exists to provide technical assistance and training services on a national scale. Their accomplishments include:

- During FY 1999, CAPTs provided technical assistance to virtually all the SIG sub-recipients to help them identify and apply the latest research-based knowledge and effective methods of substance abuse prevention programs, practices, and policies.
  - In FY 1999, the CAPTs delivered their services in collaboration with agencies responsible for substance abuse prevention services in all SIGs and at least 94 percent of sub-recipients.
- S The CAPTs also provided requested training and technical assistance services to the remaining 29 non-SIG States as well as to all U.S. Territorial governments and about 20 percent of the Native American Tribal agencies. Further, the CAPTs provided services to approximately 20,000 prevention programs and practitioners.

### 3. HIV/AIDS Prevention

Citing a chronic and overwhelmingly disproportionate burden of HIV/AIDS on communities of color, in October 1998, President Clinton outlined a new comprehensive initiative. It included unprecedented efforts to improve the Nation's effectiveness in preventing and treating HIV/AIDS in the African American community and other communities of color. The Congressional Black Caucus (CBC) called for a public health emergency, predicated on statistics demonstrating the disproportionate impact of HIV disease in the African American community.

In FY 1999, CSAP launched a new \$13.5 million, multi-component, Substance Abuse Prevention and HIV Prevention Initiative designed to address the well-documented nexus between these two devastating public health problems. The Initiative addresses the need to integrate prior discrete and separate prevention services to maximize their effectiveness, improve client/consumer outcomes, and prevent, delay or reduce transmission of HIV associated with substance abuse behaviors. CSAP placed emphasis within its program on populations experiencing high incidence of substance abuse/HIV problems, including African American youth and women of color.

Under this program, forty-eight grants were awarded in September, 1999. While they are currently too new for preliminary findings, the program is expected to strengthen integration of HIV and substance abuse prevention at the local level, increase the provision of integrated prevention services to African-American and other racial/ethnic youth and women, and identify best practices for further application in the field.

Funding for the Targeted Capacity Expansion program for the last five years is as follows:

	<u>Funding</u>	<u>FTE</u>
1996	—	---
1997	—	---
1998	\$6,679,000	—
1999	\$78,218,000	—
2000	\$80,283,000	—

#### ***Rationale for the Budget Request***

The FY 2001 budget requests an increase of nearly \$5 million in new funds for the Targeted Capacity Expansion program. CSAP will award 14 to 16 new SIG awards in FY 2001 to reach over eighty percent of the States (cumulatively) and facilitate critical prevention system and practice improvements. CAPT training capacity will be enhanced and HIV programs will be continued. Other mechanisms for the support of State prevention infrastructure needs will be explored as well as consideration in developing future policies to include a matching requirement from the State.

CSAP is developing a review process of options for SIG funding based on State specific data from the

expanded National Household Survey on Drug Abuse, available in August, 2000. In addition, changes in the program structure based on qualitative and process data gathered to date will be considered. The first modification considered requires State matching funds. It is expected a matching requirement ensures a greater commitment by the State to sustain long term prevention funding. An analysis of states' total prevention expenditures for FY 1995 indicates a wide range in the level of State Support. In 23 States, State revenues accounted for less than 10% of prevention expenditures; at least 15 of these States spent no State funds for prevention at all. The second modification considered permits adjustments in the total amount of State SIG awards, based on criteria such as percentage of state population under 18 years of age and State-specific results of the National Household Survey on Drug Abuse.

**C. Center for Substance Abuse Prevention**  
**3. High Risk Youth**

	<b><u>1999 Actual</u></b>	<b><u>2000 Pre-rescission Appropriation</u></b>	<b><u>2000 Final Appropriation</u></b>	<b><u>2001 Estimate</u></b>	<b><u>Increase or Decrease</u></b>
<b>BA .....</b>	<b>\$6,991,000</b>	<b>\$7,000,000</b>	<b>\$7,000,000</b>	<b>\$7,000,000</b>	<b>—</b>

**2001 Authorization**

**PHSA Section 501.....Indefinite**

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***Purpose and Method of Operation***

The initial High Risk Youth Grant Program, started in 1987, is CSAP's first knowledge development activity. The goal of this program is to prevent substance abuse and associated precursors (e.g, aggression, violence, depression, and school drop-out) in high risk youth. Many of the grants funded over the years test the most effective models of prevention with ethnic youth. Recently, the emphasis of this High Risk Youth Program has been focused primarily on supporting the National Drug Control Strategy Goal to increase the number of mentors and adults helping to educate youth about the dangers of drug use.

In FY 1998, CSAP initiated Project Youth Connect (PYC), mentoring/ advocacy models focusing on youth ages 9 -15 and their families. Building upon knowledge gained from previous CSAP-supported mentoring programs as well as the prevention literature, the PYC projects are designed to prevent and or reduce substance abuse or delay its onset, by improving school bonding and academic performance and by improving life management skills and family bonding and functioning.

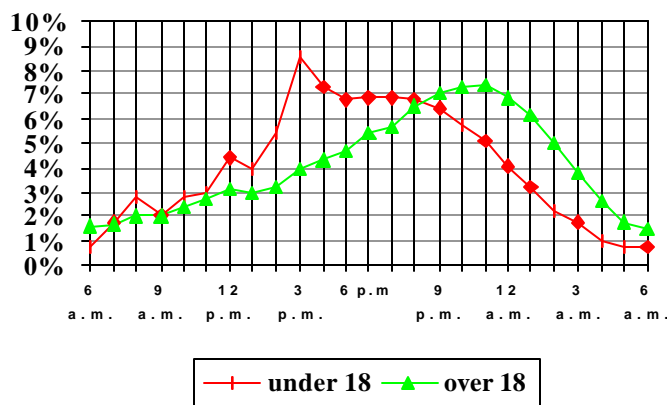
CSAP's High Risk Youth Grant Program has demonstrated a number of positive youth development approaches proven effective in reducing problem behaviors in high risk youth. CSAP is disseminating the most effective exemplary High Risk Youth programs through their *Here's Proof Prevention Works* kit and publications. Examples of these exemplary programs are Smart Leaders and FAN Club programs and Cross Ages intergenerational mentoring program. Both of these exemplary model programs involve a type of mentoring. Positive youth development activities also include tutoring or assistance with school projects, leadership training, recreational and vocational training, and community service. A major venue for positive youth development activities is after school or summer school programs, where youth participate in recreational activities, performing arts, or community services. Positive youth development programs may be based in any number of community settings including churches and other faith-based organizations, recreational centers, and senior centers. The most successful after school programs also employ life skills curriculum and community service.

Research conducted by the Federal Bureau of Investigation between 1991 - 1996 reveals the critical time periods when youth are most vulnerable to engaging in violent crime, peaking at 3 p.m. The following graph clearly demonstrates the need for more pro-social activities for minors, particularly during after school hours. Most needed are adult supervised prevention interventions provided during these high risk hours. If youth are engaged in activities geared to positive development, it is anticipated communities will realize substantial reductions in both violence and substance abuse.

**Project Youth Connect.** These High Risk Youth projects support a diverse array of mentoring models, but all employ trained mentors committed to intensive periods of involvement with youth. The intent is to determine whether intensive involvement with formally trained mentor/advocates is more likely to positively impact young people at an earlier stage. The ultimate goal, however, is to link the youth with a volunteer mentor from the community who can remain a part of the youth's life after he/she is no longer in the program. After 6 months of intensive interaction with the youth, the professional mentor is instrumental in linking the youth with a community volunteer. During the ensuing six months, the youth interacts with both the professional and the volunteer mentor, finally transitioning into a one-on-one relationship with the volunteer.

It is expected new HRY interventions will be effective in reducing substance abuse and related violence, as well as in improving community attitudes toward youth and enhancing the system of support available to youth and their families. In addition to alcohol, tobacco, and illicit drug use and attitudes, information on the following is being collected: 1) improved school bonding, grades and attendance (e.g., school bonding scale of the National Youth Survey); 2) improved parent/care giver attachment and parental supervision (11 items from the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Causes and Correlates Study); 3) improved life management skills such as peer refusal, problem solving, self efficacy, cultural pride and peer relations. Grants under this program were awarded in September, 1998, with implementation in all sites started by summer, 1999. The programs are too new to supply outcome data.

Percent of serious violent incidents in age group



**Study of Risk Factors for Drug Use During Adolescence.** Recently, results from the High Risk Youth Program cross-site study, sampling over 10,500 youth participating in recent HRY grants, revealed the factors either placing these youth at risk or protecting them. The major risk and protective precursors of tobacco, alcohol, and drug use in youth were profiled by age. The study revealed protective factors decrease systematically during the critical middle school years (ages 11 - 15). These data explain why programs specifically targeted to middle school youth focusing on increasing protective factors such as family and school bonding are the most effective in preventing tobacco, alcohol, and illicit drug use. Hence, a window of opportunity for prevention of tobacco, alcohol, and drug use and is prior to age 15. However,

older youth and adults also need prevention messages and supportive environments. These findings suggest if a youth does not initiate substance use by 15 years of age, the risk is much lower of ever becoming an addict or alcoholic. When targeting scarce prevention resources, we have chosen to focus primarily on programs for high risk youth in middle school or earlier.

***Pathways to Drug Abuse Study.*** CSAP also conducted an analysis of reasons why youth use tobacco, alcohol, and drugs. Using a sample of 8,500 high risk youth, we determined the strongest predictor of later drug use is association with friends who use drugs. However, the major predictor of a youth who will associate with friends who abuse drugs is the family's norms supporting tobacco, alcohol or drug use, little parental supervision and monitoring of the teenager's activities, and little family support and care. The study also showed by increasing protective factors such as family attachment and supervision, effective parenting, school pride and attachment, and by improving behavioral management through life and anger management skills ultimately there will be a decrease in the likelihood of youth substance abuse and violent behavior. Girls were found to be more strongly influenced by their relationships to their families. Boys were influenced somewhat more than girls by the community tobacco, alcohol, and illicit drug norms and environment. The precursors for substance use were also analyzed for each of the ethnic groups to help prevention providers better target the most effective approaches of prevention for these youth.

***High Risk Youth Program Outcome Study.*** The results of the pre- and post-tests using the same Core Measures Instrument, revealed the grant program had produced reductions in substance abuse in youth participating in the program. It documents statistically significant reductions in 30 day substance use, cigarette use, alcohol use, and marijuana use, although not inhalant use, for 12 - 17 year olds participating in the High Risk Youth grants.

Funding for the High Risk Youth program during the last five years has been as follows:

	<u>Funding</u>	<u>FTE</u>
1996	---	—
1997	—	---
1998	\$6,000,000	—
1999	\$6,991,000	—
2000	\$7,000,000	—

### ***Rationale for the Budget Request***

The FY 2001 budget requests \$7.0 million for the High Risk Youth program, the same as the FY 2000 appropriation. This level is sufficient to continue all ongoing program efforts and allow CSAP to: 1) focus on an even higher risk group of youth, including children of alcohol and drug abusers, siblings of youth in the juvenile justice system, girls who have dropped out of school, and homeless youth, and 2) address latch-key youth who are in need of adult supervision during high risk hours for tobacco, alcohol, and drug use (i.e., after school).

Like the KDA Community-initiated Grant Program, the High Risk Youth Program will permit applicants to

determine the most effective prevention approach for the targeted high risk youth population in their community. Programs must select the most appropriate approach from the list of exemplary prevention programs in CSAP's National Registry of Effective Prevention Programs. The seven exemplary High Risk Youth Program Models currently being disseminated through the publication, *Here's Proof Prevention Works* (CSAP, 1999) will be recommended for implementation. They will be asked to field-test them with new high risk youth populations and to develop appropriate materials (e. g., written curriculum, videos, and evaluation instruments) for dissemination of the program to other similar target populations (rural youth, American Indian youth, juvenile justice youth, etc.).

**C. Center for Substance Abuse Prevention**  
**4. Substance Abuse Prevention and Treatment Block Grant (SAPTBG)**

	<b>1999 <u>Actual</u></b>	<b>2000 Pre-rescission <u>Appropriation</u></b>	<b>2000 Final <u>Appropriation</u></b>	<b>2001 <u>Estimate</u></b>	<b>Increase or <u>Decrease</u></b>
<b>BA .....</b>	<b>\$301,150,000</b>	<b>\$304,000,000</b>	<b>\$304,000,000</b>	<b>\$309,890,000</b>	<b>+\$5,890,000</b>

**Purpose and Method of Operation**

CSAP administers the primary prevention component of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) as it applies to all 50 States, 10 jurisdictions, and one Indian Tribe. The Block Grant 20 percent prevention set-aside program is one of the largest substance abuse prevention programs funded by the Federal government. Twenty percent of the SAPTBG funds allocated to States according to legislative formula must be spent on substance abuse primary prevention services. States vary widely in the extensiveness and scope of their prevention services. While some States depend entirely on the 20 percent set-aside to support their activities, others use these funds to fill gaps and enhance existing programs' impact.

Specific examples of the outcomes from States' use of these funds are:

- The Massachusetts Bureau of Substance Abuse Services spent approximately \$7 million to support a range of alcohol, tobacco and other drug prevention services for groups at risk. The substance abuse prevention program includes ten regional centers serving as a network for technical assistance, information dissemination, and support to community groups and organizations, including coalitions, schools, youth agencies, health programs, and faith communities. Special emphasis was given to programs serving high risk youth addressing youth development and peer leadership, student assistance, court diversion, and street outreach in Boston.
- The Missouri Division of Alcohol and Drug Abuse focused its \$4.8 million in substance abuse prevention funds on a network of 12 regional Community 2000 Support Centers assisting in developint and maintaining over 140 community coalitions. The Support Centers assisted the coalitions with needs assessment, planning, evaluation and training.
- The Illinois Bureau of Substance Abuse Prevention directed the expenditures of its \$12.2 million in substance abuse prevention funds through a strategic planning process for prevention developing prevention goals and objectives with specific outcomes. Prevention goals are to 1) increase knowledge and involvement of stakeholders, 2) provide highest quality services, and 3) develop an effective service delivery system. Key to this effort is the objective to provide prevention services for all residents, with a goal of reducing substance abuse by three percent each year.

- Montana's Chemical Dependency Bureau guided the use of \$1.1 million in substance abuse prevention funds with a carefully executed, statewide needs assessment process, using the *Communities That Care* model. Working through the 12 units of the Montana Association of Counties, lead prevention programs were designated in each unit to develop capacities for training, information dissemination, needs assessment, and planning. Two measurable, statewide substance abuse prevention outcomes were set: 1) to decrease the percentage of youth who have their first alcoholic drink, and 2) to decrease the percentage of youth who smoke cigarettes on ten or more days a month.
- States have progressed in their ability to comply with the Synar Amendment. In the past year, State authorities have made significant progress in developing enforcement infrastructures to reduce the sale of tobacco products to minors. The median noncompliance rate of sales to minors as reported by the States in 1999 was 21.6 percent. This is a significant reduction from the median rate of 40.1 percent in 1997 and pre-1997 studies that found noncompliance rates ranging from 60 to 90 percent. Twenty-one States reported 1999 noncompliance rates of 20 percent or less. Three States reported noncompliance rates of under 10 percent. All States have plans in place to ensure their noncompliance rate is 20 percent or less by the close of FY 2002.

Funding for the Substance Abuse Prevention Block Grant program during the last five years has been as follows:

	<u>Funding</u>	<u>FTE</u>
1996	\$246,821,000	10
1997	\$248,920,000	10
1998	\$248,920,000	10
1999	\$301,150,000	10
2000	\$304,000,000	12

### ***Rationale for the budget Request***

A total of five percent of the Block Grant annual appropriation is required to be set-aside for Federal data collection, evaluation of programs supported by the Block Grant, and technical assistance. Of this five percent, 20% is available for prevention support. Set aside funds are used to conduct and analyze data from needs assessment studies; to improve program planning, development and services delivery; to provide on site technical assistance, and for other services to enable State agencies to maximize the effectiveness of their investment in prevention.

CSAP will continue to use their portion of the set-aside for improvement of State prevention systems. CSAP uses the funds to develop and implement advanced prevention methodology for all components of State prevention systems including systems for data collection and performance measurement. Specific examples of activities to be continued in FY2001 include:

State Needs Assessment: This successful CSAP Program has supported 30 States over the past five years. It assists States in targeting their prevention programming and resource allocation by providing scientifically sound, quantitative data on specific populations and localities while identifying distribution of particular risk factors, incidence, and prevalence at the State and local levels. It also provides an inter-State forum for the exchange of effective needs assessments methodologies, technologies, and applications. States are required to conduct a core set of studies, including school-based, archival, and community resource assessments. States may also propose State specific studies reflecting unique State concerns, e.g., needs related to Native American and homeless populations. This support has resulted in an increase States reporting needs assessment results in their Block Grant applications. The data have been invaluable. For example:

- The results of a CSAP-funded middle school survey showed the need for targeting more prevention programs to youth during their middle school years, a transition from childhood to adolescence. As a consequence, New Jersey launched the “Systematic Drug Abuse Initiative: Peers Leading Peers in the War Against Drugs” which includes 50 middle schools each year.
- In Texas, information from CSAP’s needs assessment determined which populations were particularly underserved. These results are being used to justify program services for those under served populations, specifically targeting Hispanics and college students.
- In Utah, the Department of Education recognized the importance of the prevention needs assessment data and used it for allocating Drug-Free Schools funds.

***Technical Assistance and Site Visits to the States:*** CSAP has provided TA activities to more than 45 States and jurisdictions to support their substance abuse prevention systems. TA has been provided on-site, by telephone, and in multi-State formats. Primary areas of assistance provided include: planning (e.g., developing a State-wide plan, developing outcome measures), workforce development and staff training (e.g., developing a plan for credentialing and certification), overall system and management issues, monitoring, needs assessment (e.g., risk and protective factors and results mapping), and program evaluation.

CSAP is developing revised guides for conducting technical reviews of the States’ management and implementation of the requirements and conditions of the SAPTBG, including implementation of Synar regulations. CSAP will continue to provide support for all States’ efforts and monitor their progress to ensure they are making every effort to reduce illegal sales of tobacco products to minors as mandated by the Synar Amendment.

CSAP’s technical assistance to States has received a 94% satisfactory rating from our State customers. Moreover, 100% of States have received technical assistance in implementing the Synar program, up from 20% in FY97. Synar technical assistance includes but is not limited to the provision of help in developing retailer lists, identifying outlets, developing merchant education programs, providing assistance with technological interventions, community mobilization programs, and improving collaboration between state and local authorities responsible for complying with Synar requirements.

***Performance Measurement:*** In 1997, twenty-seven states convened to discuss prevention performance outcome measures. Results of that meeting, CSAP mission measures and SIG core measures led to the FY 2000 SAPT block grant now including optional forms, approved by OMB, that States can use to voluntarily report on five outcome measures for Block Grant funded programs. CSAP is working with interested States to reach agreement and finalize SAPT Block Grant priority outcome indicators, identify obstacles to State reporting and mechanisms for overcoming these barriers, and agree to reasonable time lines for national implementation of Block Grant outcome reporting.

***Minimum Data Set:*** A Minimum Data Set (MDS) initiative has been underway to support States' collection of data on the number and types of prevention services provided and populations served. States use common data items, common definitions, and common methods of data collection. CSAP has supported the development and implementation of a PC based software system and the technical assistance related to training and installation. More advanced Phase I software is being developed. As of July, 1999, twenty states are using or implementing MDSI. MDSI allows the provider, the substate entity and the state as a whole to identify the types of activities being provided to a variety of population groups, e.g., demographic groups, high risk populations, providers, etc. States then use the results to more effectively target and allocate resources and improve State planning for prevention programs. Two examples of MDSI States include:

- Colorado has developed their MDSI system to collect demographic, program, and activity information on all of their service providers. The State has also developed a program evaluation system to monitor provider planning and implementation efforts. Using these two systems, Colorado now has the ability to plan, design, and develop program services and strategies that meet the prevention needs of the State.
- Pennsylvania has also developed their MDSI system to monitor local planning, programming, and service provision. Based on the MDSI data collection effort, Pennsylvania officials developed future program goals in terms of planning prevention activities, the clientele to be served, and defining effective strategies.

## D. Center for Substance Abuse Treatment Overview

	<b>1999 Actual</b>	<b>2000 Pre-rescission Appropriation</b>	<b>2000 Final Appropriation</b>	<b>2001 Estimate</b>	<b>Increase or Decrease</b>
<b>BA</b>					
KD&A . . . .	\$115,297,000	\$100,259,000	\$100,259,000	\$95,259,000	-\$5,000,000
TCE . . . . .	55,089,000	114,307,000	114,307,000	163,161,000	+48,854,000
SAPT Blk					
Grant . . . .	1,585,000,000	1,600,000,000	1,600,000,000	1,631,000,000	+31,000,000
<b>Total . . . .</b>	<b>\$1,755,386,000</b>	<b>\$1,814,566,000</b>	<b>\$1,814,566,000</b>	<b>\$1,889,420,000</b>	<b>+\$74,854,000</b>

Substance abuse treatment has been conclusively shown to be effective in reducing drug use as well as the attendant social costs (health care, criminal justice, homelessness, etc.). CSAT's National Treatment Improvement Evaluation Study demonstrated a 50 percent decrease in drug and alcohol use one year after completing treatment. The Drug Abuse Treatment Outcomes Study corroborated the findings from the CSAT study, and the Services Research Outcomes Study also showed significant decreases in illicit drug use five years following treatment.

A new initiative was undertaken in 1999 to improve the availability, accessibility and quality of substance abuse treatment services nationwide. This initiative, ***Changing the Conversation: The National Plan to Improve Substance Abuse Treatment (NTP)***, involves a comprehensive analysis of five specific areas related to funding for and access to service delivery systems, public attitudes and beliefs, and best practices and treatment methods for addressing substance abuse and addictions. Those five areas or domains are: 1) closing the treatment gap; 2) reducing stigma and changing attitudes; 3) improving and strengthening treatment systems; 4) connecting services and research; and, 5) addressing workforce issues. A series of stakeholder meetings were held, bringing research and treatment professionals together, and six public hearings held nationwide received testimony from more than 420 witnesses. This effort will lead to a comprehensive report reflective of findings and recommendations. The report will be the foundation to guide subsequent program planning for CSAT and future action for the treatment field, and will be shared with other federal entities involved with substance abuse and addiction issues. While the final report is not expected until early this summer, CSAT has already begun to address preliminary findings from the NTP in its activities and programs.

While treatment is known to be effective, a gap in the availability of treatment continues to exist. The substance abuse treatment field typically defines the treatment gap in one of three ways:

- 1) ***availability and demand:*** The amount of services available related to the prevalence of addiction disorders and the number of individuals who identify themselves as interested in entering treatment;
- 2) ***access and demand:*** The services utilized in relation to penetration rates of services (geographic and

other availability of services), actual prevalence of disorders, and the number of individuals who identify themselves as interested in entering treatment;

3) ***funding and demand***: The dollars actually allocated by service type in relation to the prevalence of addiction disorders and the number of individuals who utilize services.

Closing the treatment gap is an issue of ensuring that people in need of treatment receive it; that sufficient resources are available to deliver the quantity of services needed; and that the types and levels of care needed are available. Closing the treatment gap is especially important to those who could benefit from early intervention and immediate treatment, in order to prevent the development of long term drug and alcohol problems. The Center for Substance Abuse Treatment has adopted the National Drug Control Strategy model for the treatment gap as well as the health and social costs associated with drug use. The targets established by ONDCP for reducing the treatment gap are a 20% reduction by FY 2002 and a 50% reduction by FY 2007. The specific performance measures, at are proposed for tracking progress on these goals are:

- 1) Reduction in the treatment gap
- 2) Reduction in waiting time for treatment, and
- 3) Improved client outcomes.

Only by engaging in a balanced set of programs focused on each of these targets will it be possible to achieve the goals set forth in the National Drug Control Strategy. CSAT programs also support the Department's disease prevention and health promotion activities including Healthy People 2010, *Women's Health* and *Reducing Racial Disparities in Health Status*. These activities constitute the heart of SAMHSA's 2001 request based on a strategy to improve the accountability of and access to appropriate treatment services that deliver quality care. The following discussion presents specific CSAT activities and the respective Drug Strategy targets that they are intended to affect.

#### Reduction in the Treatment Gap Through Increased Availability of Treatment

At the center of this Nation's substance abuse problem is the lack of a comprehensive national system for treating of alcoholics and illicit drug users. Making effective treatment more available is key to correcting this problem.

Approximately 14 million people are current users of illicit drugs, with 2.58 million users between the ages of 12-17 and 4.06 million between the ages of 18-25. Data indicate that 5.7 million Americans who are abusing or are dependent on drugs are severely in need of addiction treatment. ONDCP reports that existing treatment capacity is sufficient for only about 20% of adolescents in immediate need of treatment and that there are an estimated 4 million chronic drug users. They also state that the National Association of Drug Court Professionals has reported one of the main obstacles to increasing the number of drug courts is that the need for increased treatment resources is becoming more acute. Of these individuals, only 2.1 million can be served through the existing publicly funded treatment system, leaving a gap of 3.6 million people severely needing substance abuse treatment. According to SAMHSA estimates, closing the

treatment gap would require spending up to \$8 billion at the Federal level.

When the treatment needs of problem drinkers are also taken into consideration, the treatment gap only widens. Of the estimated 111 million Americans who drink alcohol, approximately 32 million report one or more alcohol-related problems. Approximately 4.6 million adolescents between the ages of 12-17 are current users of alcohol; these underage individuals, by definition, are problem drinkers.

Two programs integral to reducing the treatment gap are the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Targeted Capacity Expansion (TCE) Program. Groundwork for the TCE effort was completed in 1998, and significant increases were received in 1999 for both TCE and SAPT Block Grant programs. The FY 2001 request includes increases for both programs.

The TCE program is specifically designed to address gaps in local treatment capacity by supporting rapid and strategic responses to the demand for alcohol and drug abuse treatment services and through targeting vulnerable, hard-to-reach populations. States target SAPT Block Grant funds to service needs by incorporating data on new and emerging problems in their planning and allocation strategies, but insufficient funding and previous resource commitments often adversely affect their capability to rapidly address newly identified service needs. The goal of the TCE program is to provide local communities the opportunity to create or expand service capacity through an integrated, creative, timely, and community-based response to a targeted, well-documented substance abuse treatment capacity problem. Treatment services supported under TCE must be based on sound, scientifically-based theory or empirical evidence of effectiveness.

In an effort to target funding at local communities facing these and many other treatment issues, in FY 2001 CSAT proposes to create comprehensive systems of care in smaller towns, rural areas, and mid-size cities. This expansion of targeted programs, called strengthening communities, will focus on encouraging the development of creative and comprehensive drug and alcohol early intervention and treatment systems for adults, but it will also have an important adolescent component. Other populations targeted by Strengthening Communities include women, homeless, co-morbid, rural, and poly-substance abusers.

The health care system for adolescents is fragmented, insufficiently informed about specific adolescent problems, and ill equipped to effectively address many of the problems with which teens present, especially given that many teens present with poly-drug use needs (e.g., alcohol and marijuana and heroin). Youth do not do well in treatment programs designed for adults; rather, they need programs designed to meet their specific needs. For example, traditional 12-step addiction recovery programs usually are, adjusted for teens to focus on the first five steps, which are more developmentally appropriate for adolescents. Residential treatment programs need to be less confrontational for teens than adults and some teens may need treatment longer than the standard 28 days (Treatment Improvement Protocol #31 - *Screening and Assessing Adolescents for Substance Use Disorders*, 1999).

Building upon program expansion to be accomplished in FY 2000, CSAT will also fund additional grants in the TCE-HIV/AIDS initiative. These efforts, which began with funding provided by the Congressional Black Caucus in FY 1999, focus on enhancement and expansion of substance abuse treatment services

related to HIV/AIDS in African-American, Hispanic, and other racial/ethnic minority communities affected by the twin epidemics of substance abuse and HIV/AIDS.

The SAPT Block Grant remains the primary tool the Federal government uses to support and expand substance abuse prevention and treatment services. Federal funding for public treatment facilities, as a percentage of all funding being used at the State level for substance abuse treatment, ranges from a low of 11% in one State to a high of 84% in another. Increased funding is necessary to accommodate higher service costs as well as to provide for additional service capacity. The proposed \$1.631 billion funding level for the SAPT Block Grant, together with other CSAT treatment program funding increases requested for FY 2001, would provide treatment for approximately 414,000. Due to the leveraging effect the Block Grant has on State and local governments, total treatment capacity through publicly-funded programs in FY 2001 will serve an estimated 900,000 persons.

#### Reduction in Waiting Time Through Improved Access to Treatment

In addition to the obvious need for additional treatment capacity, reducing barriers to treatment and improving access are essential components to achieving the target of reducing the waiting time for treatment. Access to treatment services is a significant issue which cuts across numerous populations. Even with significant advances in the art, science and technology of substance abuse treatment, little improvement will occur in the overall health of the population if they cannot access the care they need.

Often, the waiting time to enter treatment deters substance abusers from actually entering. There are extensive waiting lists for treatment and ancillary services in many States. People who are not easy to contact, such as homeless people, are often dropped from the lists. There are many other barriers to treatment including inadequate financial resources; lack of timely treatment; lack of child care, outreach and other related services; lack of easy physical access; and a variety of other barriers. The *Strengthening Communities* initiative will encourage the development of creative, comprehensive and accessible drug and alcohol treatment systems in locations with continuing major drug problems. CSAT plans to continue its work on parity for substance abuse treatment services as well as on the need for gender, culturally and linguistically appropriate services. Continuation of the Recovery Community Support Program will assist in providing the recovery community with a public voice to communicate its unique perspectives and insights regarding the formal delivery systems, as well as heighten public awareness and deal with anti-stigma issues.

#### Improved Effectiveness, Quality and Outcomes of Treatment

Central to treatment success is the adoption of best practices within the service system. Recently acquired knowledge provides the impetus for a greater focus on knowledge application activities in FY 2001. These activities will include product development and dissemination activities as well as technology transfer and training.

The FY 2001 request proposes continuation of the Practice/Research Collaboratives program, designed to bring researchers, providers, and other community leaders together to review available data on substance abuse treatment, develop plans to improve services, and conduct studies needed to assure that

improvements are made. Another component of this effort is the expansion and broadening of an existing network of curriculum developers, trainers and consultants that is regionally based and sensitive to particular needs of that region.

CSAT, together with its State partners and the treatment community, is actively engaged in the development of performance and outcome measurement instruments and monitoring systems. The goal of these technologies is to make the provider community more accountable by having more effective, data-based monitoring of treatment activities.

CSAT is also assuming responsibility for oversight and monitoring of treatment quality in the nation's opioid addiction treatment system. This involves Federally approved programs and individual practitioners that use anti-addiction medications such as methadone, levo-acetyl-alpha-methadol (LAAM) and newer medications currently under research (e.g., buprenorphine). More focus will be directed to the need for treatment providers to upgrade the quality of services and pay more attention to the outcomes of care.

Substance abuse affects a wide range of other social service systems (e.g., health, mental health, criminal justice, welfare, labor, etc.). Agencies across the Department of Health and Human Services, and across all of the Federal Government, as well as States, local communities and providers, must work in concert to reduce substance use and abuse. In FY 2001, CSAT plans to continue partnering efforts with: NIAAA, in evaluating adolescent alcohol treatment strategies and preventing DUI recidivism; CDC, in looking at substance abuse and HIV; NIDA, in collaborating on effective treatment approaches; and, the Department of Justice, in assuring current technical assistance for substance abuse treatment in the justice system. In addition to these types of ongoing activities, CSAT plans to form new partnerships looking at welfare and job training, expanding family drug courts, providing substance abuse treatment services for the cognitively and physically disabled, and other opportunities for collaboration as they arise.

The substance abuse treatment system is a mixture of treatment modalities, clients and treatment needs. CSAT believes that only by engaging in a balanced set of activities that is targeted toward each of the areas discussed above, will it be possible to achieve the goals set in the National Drug Control Strategy of reducing the number of substance abusers and the health and social costs of drug use.

## **KDA PROGRAM ACCOMPLISHMENT**

### **Program/Initiative: RWC/PPW CROSS-SITE EVALUATION**

In FY 1996, CSAT initiated a cross-site evaluation of 24 Pregnant and Postpartum Women (PPW) Demonstration Programs grantees and 26 Residential Women and Children (RWC) grantees. The evaluation focused on the effectiveness of the programs in reducing substance abuse and illegal activities among the women; factors that contribute to retention in residential treatment, successful completion of treatment, and treatment outcomes; and, improvement in the overall health and welfare of children who participate in residential treatment with their mothers. All findings to date are preliminary, but some strong trends appear in preliminary analyses.

#### **Goal 1: Treatment Retention and Length of Stay**

Retention in treatment and completion of treatment are goals of RWC/PPW programs, since many studies find that a longer length of stay and treatment completion are linked to better treatment outcomes.

##### **Findings:**

- ! The average client length of stay in the programs was 151 days (about 5 months).
- ! Women who brought infants or young children with them into RWC/PPW treatment had higher program completion rates and longer average length of stay than women who did not bring any of their children into treatment.

#### **Goal 2: Infant Morbidity and Mortality**

##### **Findings:**

- ! Preliminary findings strongly support the value of residential substance abuse treatment for pregnant women in reducing adverse birth outcome. The percentage of low birth weight births among PPW pregnancies (5.7%) was far lower than the average rate for drug-exposed infants (30%), based on prior studies of prenatal drug use, and lower than the national rate of 7.5 % for the general population.
- ! The beneficial effects of treatment in reducing rates of pre-term and low birth weight deliveries were especially pronounced among African-American women. Rates of adverse outcomes of in-treatment pregnancies were not just lower than would be expected for substance abusing women, but considerably lower than are seen in the general population. Compared to rates of low birth weight delivery of 30 % among all substance abusing women and of 13 % among African-American women in the general population, the rate of low birth weight deliveries among African-American PPW clients was 6.7 %.
- ! Prior to entering treatment, the percentage of reported infant deaths among PPW clients was 1.5 %, twice the national average (0.7%). The PPW/RWC program infant mortality rate of 0.3 %, is far below

the expected rate for substance-abusing women and lower than the national average.

PREGNANCY OUTCOME FINDINGS FOR PPW CLIENTS <sup>1</sup>			
MORTALITY/MORBIDITY INDICATOR	ALL U.S. WOMEN 1997 <sup>2</sup>	PPW CLIENTS	
		PRIOR PREGNANCIES (N=4,218 LBs)	TREATMENT PREGNANCIES (N=592 LBs)
MORTALITY			
Fetal mortality rate (per 100 LBs and FDs)	0.7 <sup>3</sup>	7.7	1.5
Infant mortality rate (per 100 LBs)	0.7 <sup>4</sup>	1.5	0.3
MORBIDITY			
Low birth weight rate (per 100 LBs)	7.5 <sup>5</sup>	6.8	5.7
Pre-term delivery rate (per 100 LBs)	11.4 <sup>6</sup>	6.9	7.3
NICU rate (per 100 LBs) <sup>7</sup>	-	5.5	10.6
AOD-positive rate (per 100 LBs) <sup>8</sup>	-	10.7	9.1

<sup>1</sup> LB = live birth; FD = fetal death (miscarriage or stillbirth).

<sup>2</sup> Source: MacDorman, M. & Atkinson, J. Infant mortality statistics from the 1997 period linked birth/infant death data set. National Vital Statistics Report; vol 47 no. 23. Hyattsville, MD: National Center for Health Statistics).

<sup>3</sup> Number of fetal deaths of 20 weeks or more gestation per 100 live births plus fetal deaths.

<sup>4</sup> Number of infant deaths (under one year of age) per 100 live births.

<sup>5</sup> Less than 2,500 grams (5 lbs., 8 oz.).

<sup>6</sup> Births of less than 37 completed weeks of gestation.

<sup>7</sup> Number of infants who received treatment in a hospital Neonatal Intensive Care Unit per 100 live births.

<sup>8</sup> Number of infants who tested positive for alcohol or drugs per 100 live births.

### Goal 3: Changes in Women's Behavior

Reducing drug use and involvement in criminal behaviors are two major objectives of the RWC/PPW programs. Client behaviors were compared during the 6 months following treatment to their pre-treatment behaviors.



**Findings (preliminary):**

- ! Women in RWC/PPW programs demonstrated significant reductions in the use of drugs and alcohol after treatment, with treatment completers demonstrating greater reductions in substance use compared to non-completers.
- ! Both RWC/PPW treatment completers and non-completers reported far less involvement in illegal activities after treatment, with completers demonstrating a greater reduction in illegal activities than non-completers. Among completers, 52 % reported involvement in illegal activities in the 30 days prior to admission while 13 % reported involvement in illegal activities in the 30 days prior to their post-treatment interviews. Among non-completers, 45 % reported involvement in illegal activities in the 30 days prior to admission versus 20 % in the 30 days prior to their follow-up interviews.

**Goal 4: Family Preservation**

Many clients were at high risk for losing custody of their children, or had already lost custody of their children at the time of treatment entry. Another objective of these programs was to see if RWC/PPW treatment participation might influence preservation of the family.

**Findings (preliminary):**

- ! Treatment participation and completion were positively related to the retention of child custody; 95 % of children who entered treatment with their mothers remained in their mothers' care at treatment exit if their mothers completed treatment.
- ! Approximately 75 % of children who were in foster care just prior to admission were discharged to their mothers' custody at treatment exit.

**Application:**

The results of the RWC/PPW cross-site evaluation are preliminary. When final results are available, they will be disseminated widely to treatment providers to put into practice.

## **KDA PROGRAM ACCOMPLISHMENT**

### **Program/Initiative: MARIJUANA TREATMENT PROJECT (MTP)**

The MTP (Marijuana Treatment Project), is a three-year, randomized clinical trial investigating the effectiveness of brief interventions for individuals who are dependent on cannabis. The project compared two focused treatments for dependent individuals from differing socio-economic and racial backgrounds.

### **Goal: Determine Effectiveness of Brief Interventions**

! The MTP project sought answers to two primary questions:

- Are focused interventions any more effective than no treatment for marijuana problems?
- Does a nine-session treatment produce better outcomes than a two-session treatment?

### **Findings:**

- As few as two treatment sessions (brief treatment) for marijuana use produces a significant reduction in smoking behavior.
- Nine sessions (extended) produces a significant proportion of abstinence and reduction as well.
- Both the brief and extended treatment sessions are more effective than no treatment.

### **Application:**

Cannabis dependence is the most common form of dependence associated with illicit drugs. Recent surveys of publicly funded drug treatment programs, Drug Abuse Treatment Outcome Study (DATOS) and National Treatment Improvement Evaluation Study (NTIES), found that a large percentage of admissions reported the primary drug problem for which they sought treatment was marijuana use or marijuana in combination with alcohol. Despite the large number of people seeking treatment for cannabis dependence, there has been no consensus within the scientific or clinical community about the type or intensity of treatment that is optimally effective. The MTP results are being communicated to the treatment providers nationwide.

**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION**  
**Center for Substance Abuse Treatment**  
*Mechanism Table*  
(Dollars in thousands)

<b>FY 1999 Actual</b>	<b>FY 2000 Pre-Rescission Appropriation</b>	<b>FY 2000 Final Appropriation</b>	<b>FY 2001 Estimate</b>
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**Knowledge Development and Application:**    **No.**    **Amt.**    **No.**    **Amt.**    **No.**    **Amt.**    **No.**    **Amt.**

Grants/Cooperative Agreements:								
Continuations.....	131	\$56,043	150	\$44,675	150	\$44,675	117	\$55,662
Competing:								
New.....	65	18,806	31	14,000	31	14,000	30	4,500
Supplements:								
Administrative.....	---	---	---	---	---	---	---	---
Competing.....	---	---	7	1,000	7	1,000	14	7,600
Total, Grants/Cooperative Agreements.....	196	74,849	188	59,675	188	59,675	161	67,762
Contracts.....	126	39,165	125	39,534	125	39,534	67	26,947
Technical Assistance.....	16	236	15	250	15	250	15	250
Review Costs.....	10	797	10	800	10	800	4	300
<b>Total KDA.....</b>	<b>348</b>	<b>115,047</b>	<b>338</b>	<b>100,259</b>	<b>338</b>	<b>100,259</b>	<b>247</b>	<b>95,259</b>

**Targeted Capacity Expansion:**

Grants:								
Continuations.....	41	24,445	112	55,381	112	55,381	171	85,352
Competing:								
New.....	65	28,880	100	54,416	100	54,416	103	48,819
Renewal.....	---	---	---	---	---	---	41	24,445
Total, Grants.....	106	53,325	212	109,797	212	109,797	315	158,616
Contracts.....	1	1,971	5	4,465	5	4,465	5	4,500
Technical Assistance.....	---	---	---	---	---	---	---	---
Review Costs.....	7	43	7	45	7	45	7	45
<b>Total Targeted Capacity Expansion.....</b>	<b>114</b>	<b>55,339</b>	<b>224</b>	<b>114,307</b>	<b>224</b>	<b>114,307</b>	<b>327</b>	<b>163,161</b>

**Substance Abuse Block Grant:**

<b>Total, Substance Abuse Block Grant.....</b>	<b>60</b>	<b>1,585,000</b>	<b>60</b>	<b>1,600,000</b>	<b>60</b>	<b>1,600,000</b>	<b>60</b>	<b>1,631,000</b>
Set-Aside (Non-Add).....	---	(79,250)	---	(80,000)	---	(80,000)	---	(81,550)